MINUTES
MEETING OF INPATIENT PHYSICAL REHABILITATION SERVICES
TECHNICAL ADVISORY COMMITTEE
Of the Health Strategies Council
2 Peachtree Street, 34th Floor Conference Room, Atlanta, GA 30303

Friday, July 29, 2005
1:00 pm - 3:00 pm

Harve R. Bauguess, Chair, Presiding

MEMBERS PRESENT

Pamela Cartwright
Ruby Durant (for Carol Zafiratos)
Julia L. Mikell, M.D (via conference call)
Dennis Skelley, FACHE
Gary Ulicny, Ph.D.
Diane Waldner

MEMBERS ABSENT

Donald Avery, FACHE
James Coughenour
Hazel Dorsey, RN
Patricia Fraley
Edwinlyn Heyward
Ron Hunt, MD
Kathy Kleinsteuber
John Lindsey
Jan Marie Popovich
Mary Sloan, MPA
Wylene Watts
Dayna Whitley

GUESTS PRESENT

Jennifer Bach, Mitretek Healthcare
Tiffany Cohen, Mitretek Healthcare
Ruby Durant, DHR, Office of Regulatory Services
Teresa Johns, Regency Hosp Company
Elbert McQueen, Healthsouth - Macon
Diana Potts, Gwinnett Hospital System
Temple Sellers, Georgia Hospital Association
Terri Spiegel, Regency Hosp Company
David R. Tatum, Children's Healthcare of Atlanta
Leah Fressell Watkins, Powell Goldstein

STAFF PRESENT

Richard Greene, JD
Matthew Jarrard, MPA
Robert Rozier, JD
Virginia Seery, PhD
Geeta Singh, MHA
Rhathelia Stroud, JD
Stephanie Taylor

WELCOME

The meeting of the Comprehensive Inpatient Physical Rehabilitation Services Technical Advisory Committee (TAC) commenced at 1:10 pm. The Chair welcomed everyone to the meeting and asked members, guests, and staff to introduced themselves.

Following his introductory remarks, the Chair called for a motion to approve the minutes of the June 17th meeting. Mr. Skelley recommended that Dr. Ulicny's title be changed from "Mr." to "Dr." throughout the meeting minutes. A motion to accept the minutes of the June 17th meeting, pending this suggested change was made by Diane Waldner, seconded by Dr. Gary Ulicny. The approval of the minutes was postponed since there was not a quorum.

PUBLIC COMMENTS

Mr. Greene invited guests to provide public comment. No one indicated the desire to speak.

ONGOING REVIEW OF DRAFT PROPOSED RULES

Mr. Rozier reviewed the working Draft of the Proposed Rules (Appendix A)

Applicability 111-2-2-.35 (1)

- 111-2-2-.35 (1)(c)& (d)Traumatic Brain Injury (TBI) :

Mr. Rozier solicited input from members regarding whether TBI Transitional Living & Life Long Living Programs should require separate CONs and need methodologies. Dr. Ulicny said that there is no need to make a distinction between these two models of care.

Mr. Skelley stated that the current plan for TBI facilities provides a need methodology for both of these TBI categories of service. He said that combining the two TBI need methodologies would not provide a fair representation of the number of beds needed for each type of service because there are two distinct services. Further, he said that adding them together for purposes of the need methodology may project a need for additional beds.

Dr. Ulicny said that some services that are provided to patients with TBI diagnoses could be accessed in other long term care settings including assisted living, skilled nursing, etc...

Robert Rozier suggested that the decision regarding whether transitional living and life long programs should be combined should be tabled for discussion at a future meeting in order to receive a wider range of input from TAC members.

- 111-2-2-.35 (1)(e)The Spinal Cord program

This sub-section was stricken from the proposed Rules since it was combined with the need methodology for Adult inpatient physical rehab services.

***Definitions* 111-2-2-.35 (2)**

- 111-2-2-.35 (2)(a) "Adult"

Mr. Rozier reviewed the proposed revisions to the definition of "adult". This definition was proposed by the TAC at last month's meeting. Members recommended the addition of the following language following the word "medically necessary" ...."provided that the treatment days and patient census associated with patients sixteen and seventeen years of age do not exceed 10% percent of annual treatment days and annual census, respectively."

Dr. Ulicny pointed out that The Shepherd Center has always served patients with spinal cord disorders, ages 12 years and above. He added that since spinal cord and TBI programs would now be combined with adult rehab programs, the definition of "adult" should be adjusted accordingly.

Mr. Rozier said that an appropriate exception would be crafted that would allow spinal cord and TBI programs, which existed prior to the development of these proposed rules, to continue to serve patients ages 12 years and above.

All members did not agree that there was a need for a specific age exception for TBI services.

- 111-2-2-.35 (2)(b)Comprehensive Inpatient Physical Rehabilitation Program

Mr. Rozier stated that this proposed definition is the same as that in the current Rules. He noted that this definition was not discussed at previous meetings but he said that the proposed definition mirrors that of the State of Maryland and several other states.

Members commented that the proposed definition is similar to that of the Centers for Medicare and Medicaid Services (CMS). Members expressed approval and general agreement to the proposed definition.

- 111-2-2-.35 (2)(c) "Expansion" and "Expanded"

Mr. Rozier said that these definitions were agreed upon by Committee members at previous meetings.

- 111-2-2-.35 (2)(d) "Freestanding Rehabilitation Hospital"

The proposed definition is the same as that in the current Comprehensive Inpatient Physical Rehab Rules.

Dr. Ulicny's suggested the addition of additional clarifying language in the proposed definition, as italicized below: 'Freestanding Rehabilitation Hospital' means a specialized hospital organized and operated as a self-contained health care facility that provides one or more *comprehensive inpatient physical* rehabilitation programs. He said that this additional language would serve to tie this definition back to the definition of an inpatient physical rehabilitation program.

- 111-2-2-.35 (2)(e) "New"

Members had agreed to the proposed definition of "new" services at the previous meeting.

- 111-2-2-.35 (2)(f) "Official State Health Component Plan"

The proposed definition is the same as that in the current Comprehensive Inpatient Physical Rehab Rules.

- 111-2-2-.35 (2)(g) "Pediatric"

Mr. Rozier reviewed the proposed changes as follows: "....a provider will not be in violation of CON laws....., provided that the treatment days and patient census associated with patients eighteen, nineteen, twenty, and twenty-one years of age do not exceed 10 percent of annual treatment days and annual census, respectively."

Mr. Rozier noted that there would be exceptions crafted to accommodate facilities that have historically served pediatric patients outside of the age range specified in the proposed definitions.

- 111-2-2-.35 (2)(h) "Planning Area"

The proposed definition is the same as that in the current Comprehensive Inpatient Physical Rehab Rules.

- 111-2-2-.35 (2)(i)(j)(k)(l) "Traumatic Brain Injury", "Traumatic Brain Injury Facility", "Traumatic Brain Injury Life Long Living (All Ages) Program, "Traumatic Brain Injury Transitional Living (All Ages) Program

The proposed definitions were carried over from the current TBI rules. Members were encouraged to provide specific input regarding the need to make changes to these definitions.

Service-Specific Review Standards 111-2-2-.35 (3)

- 111-2-2-.35 (3)(a) Need Methodology

Mr. Rozier said that a step by step Need Methodology has been developed and would be discussed towards the end of today's meeting by Matthew Jarrard.

- 111-2-2-.35 (3)(b) Adverse Impact

No changes were made to this standard. Committee members had previously indicated a general agreement and approval of this definition. Mr. Rozier summarized the rule stating that a new or expanded facility would have to document that it would not decrease the volume of patients of existing providers in the health planning area in an amount 10% or greater.

Mr. Skelley recommended that some specific language be added to the proposed rule that would require existing providers to maintain a minimum occupancy level prior to the addition of new or expanded services. This would ensure maximum utilization of existing resources.

Mr. Rozier said that this recommendation could be incorporated into the need methodology.

- 111-2-2-.35 (3)(c) Exception to Need

Mr. Rozier summarized recommended changes to this section. He asked members to consider whether the population size of "≤40,000 people" was an appropriate measure. He said that a new program would be required to have a minimum of 20 beds. He questioned whether an area with a population size less than 40,000 people would be able to support a 20 bed facility. He said that the standard, as written, could potentially create over- bedding in the state since a provider could open a Rehab facility in a county with a population less than 40,000 that has no rehab providers within a 50 miles radius. The TAC agreed to table this discussion until the next meeting.

Mr. Rozier said that this section of the proposed rules also addresses other exceptions including cost, quality, financial access, geographic accessibility, and out of state utilization considerations.

Mr. Rozier said that the following language was added (following the word accessibility) to address concerns by members who have a considerable out of state patient base: "……; or if the applicant's annual census demonstrates 30 percent out of state utilization for the previous two years". He asked TAC members to provide a rationale for the "30 percent" number so that it could be legally defensible.

- 111-2-2-.35 (3)(d) - Minimum Bed Sizes For New Programs

Mr. Rozier briefly summarized these recommendations indicating that they should be addressed in further detail during the need methodology discussion:

  - A new Adult Rehab program must have a minimum of 20 beds in an acute care hospital and 40 beds in a freestanding hospital.
  - A new Pediatric Rehab program must have a minimum of 10 beds in an acute care hospital and 40 beds in a freestanding hospital
  - A new TBI program must have a minimum of 6 beds in an acute care hospital and no more than 30 beds without prior Department approval

Mr. Rozier asked for input from members on the appropriate category name for TBI programs such that it is not referred to as a Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living Program. Dr. Ulicny suggested that the term "Comprehensive Inpatient Physical Rehabilitation" be removed and that it should be referred to as a "TBI Transitional Living Program" and "TBI Life Long Living Program". Mr. Rozier agreed to make the recommended changes.

Mr. Rozier said that 111-2-2-.35 (3)(d)(5) would be deleted from the next draft of the proposed rules, since Spinal Cord programs were combined with Adult Comprehensive Inpatient Physical Rehabilitation programs.

- 111-2-2-.35 (3)(e) & (f) Accreditation Standards

Mr. Rozier noted that these standards were previously agreed to by the TAC.

Mr. Skelley suggested that the proposed number of months (36) that a facility would be required to acquire CARF accreditation should be lowered from 36 months to 18 months. He stated that a facility that is serious about providing a high level of care to the community should be CARF accredited within 18 months and should meet appropriate industry standards within a reasonably short period of time Members agreed with Mr. Skelley's recommendation.

Mr. Skelley asked whether language could be added to allow the Department of Community Health (DCH) to revoke a CON for a new or expanded facility that has lost its CARF accreditation or which is not CARF accredited.

Mr. Rozier responded that he would include this proposed language in the draft proposed rules however he did not believe that DCH has the statutory authority to revoke a CON for failure to achieve accreditation within a specified period of time. Mr. Rozier said that he would obtain further clarification from the Law Department.

Ruby Durant, ORS (who attended the meeting in place of Ms. Zafiratos) recommended that in addition to obtaining CARF accreditation, language should be added to the accreditation standard that requires a freestanding rehabilitation facility seeking to expand services to be in good standing with all licensure standards established by DHR. Members agreed with this recommendation. Mr. Rozier agreed to incorporate this standard into the proposed rules.

- 111-2-2-.35 (3)(g) TBI Licensure Standards

Mr. Rozier noted that language would be added to include "Freestanding Rehabilitation Hospitals" under this standard.

- 111-2-2-.35 (3)(h) Written Policies

No changes were made to this section since the previous meeting. Members expressed no general concerns.

- 111-2-2-.35 (3)(i) Referral Arrangements

No changes were made to this section since the previous meeting. Members expressed no general concerns.

- 111-2-2-.35 (3)(j) Financial Accessibility

Mr. Rozier summarized this standard, stating that a facility applying for a CON would be required to assure access to services regardless of a patient's ability to pay through written policies and documentation of the following:

  - 111-2-2-.35 (3)(j)(1) - The non-discriminatory treatment of patients (same language as current rule)
  - 111-2-2-.35 (3)(j)(2) - Indigent & charity care commitment (same language as current rule)
  - 111-2-2-.35 (3)(j)(3) - Past demonstrated performance (same language as current rule)
  - 111-2-2-.35 (3)(j)(4) – *"Providing documentation of current or proposed charges and policies, if any, regarding the amount or percentage of charges that charity patients, self pay patients, and the uninsured will be expected to pay".* This was new language inserted in the Proposed Rules, per the TAC's recommendations at previous meetings.

Mr. Rozier read the following language that was inserted in the proposed rules, based on the TAC's recommendation: *"A provider offering more than one program in Comprehensive Inpatient Physical Rehabilitation may make one written commitment for the entire service as opposed to several commitments for the various programs within the service; however, an acute care hospital may not substitute an institution-wide commitment in lieu of this service-specific commitment."*

- 111-2-2-.35 (3)(k) Financial Accessibility

Mr. Rozier pointed out that new language was added to require an applicant to meet or exceed any and all previous commitments to indigent and charity care. If the applicant has not met the commitment, they would be required to pay a fine equal to the difference in the amount of services provided and the indigent and charity care commitment that was made.

- 111-2-2-.35 (3)(l) Geographical Distribution

Mr. Rozier noted that this standard was deleted from the Proposed Rules, because it was not very substantive. It was too general. He said that there is already an exception to the need standard which addresses geographic distribution and accessibility.

- 111-2-2-.35 (3)(m) Information Requirements

The Proposed Rule is same as the current Rules, per the TAC's decision at a previous meeting.

SERVICE-SPECIFIC NEED METHODOLOGY

Mr. Jarrard reviewed the Service-Specific Need Methodology, the steps (of which are outlined in the Proposed Rules [Appendix A - 111-2-2-.35 (3) (m)].

Mr. Jarrard referenced and reviewed the following documents included in member packets: (see Appendix B)

- Comprehensive Inpatient Physical Rehabilitation: Updated Need Projection Components
  - Document provided information on 2003 discharge rate per 100, demand factor, and E-rehab average length of stay for diagnostic groups under spinal cord, adult rehab, and pediatric rehab.
- Comprehensive Inpatient Physical Rehabilitation: Need Projection Data Components from Component Plan
  - Document provided information on 1987 discharge rate per 100, demand factor, and E-rehab average length of stay for diagnostic groups under spinal cord, adult rehab, and pediatric rehab.
- Comparison of 2010 Comprehensive Inpatient Rehabilitation Need Projections, Using Existing Data Elements and Using Updated Data Elements
  - Table illustrated that the state is currently significantly over bedded
- Comprehensive Inpatient Rehabilitation Beds in Georgia per Capita Resident Population
  - Table illustrates the current CON capacity beds in the inventory for each planning area

Mr. Rozier pointed out that the need projections are based on the current definitions, as such, spinal cord programs were not rolled into the Adult Rehab category. He said that those changes would be accounted for in the final need projection.

Mr. Jarrard stated that he did not utilize the updated ICD-9 Codes. He said that projections presented at today's meeting do not take into account the impact of the 75 Percent Rule. He said that future projections would utilize the updated ICD-9 Codes.

Mr. Skelley noted that one of the areas that would be most impacted by the 75 Percent Rule is orthopedic disorders. He said that the impact of the 75 Percent Rule is expected to be severe in this diagnostic category. He said that he would expect a severe impact on inpatient admissions of patients needing joint replacements and noted that different providers are at different levels of compliance. He said that once the need projection incorporates the current ICD-9 Codes, an even greater reduction of beds would likely result since admission rates would likely decline.

Elbert McQueen, a guest at the meeting, commented that it will be important to know where patients who were traditionally treated in inpatient rehab facilities are going to access care in the future.

Mr. Skelley indicated that he recently participated in a study with the Medical College of Georgia (MCG) and University Hospital regarding Long Term Acute Care Hospitals (LTACHs) and the impact on rehab bed utilization. He noted that the study identified that 10-15% of acute care discharges that traditionally would go to comprehensive rehab facilities would potentially go to LTACHs. Mr. Skelley agreed to provide contact information to DCH in order to obtain this study.

There was some general discussion on LTACHs and whether (and how) to incorporate this model of care into the Proposed Rules. Members discussed the overlap of comprehensive inpatient rehab facilities and LTACHs and questioned how to capture an accurate need for services since both types of providers offer similar services.

Dr. Ulicny mentioned that the major difference between an LTAC and a rehab hospital is essentially the Medicare designation, noting that the type of patients admitted to each facility is driven by federal guidelines.

Diana Potts, Gwinnett Hospital System, a guest, stated that among the criteria that is used when selecting the type of facility where a patient is referred is medical need, the number of hours that a patient is able to tolerate rehab, and Length of Stay considerations. She said that in a skilled nursing facility the level of care that is provided is much different than an acute care rehab facility. She said that the referral is not clear cut for all patients.

Mr. Skelley suggested a flat percentage that takes into account the overlap between LTACHs and rehab facilities. He said that this mechanism should be subtracted from the final need projection number. The designated percentage should be based on national and local studies, such as the one conducted by the MCG and University Hospital. Members agreed with Mr. Skelley's suggestion.

Members said that they would expect a significant decrease in bed need with the implementation of the 75% Rule, however members said that it is more important to address issues of geographic accessibility and to ensure the appropriate utilization of existing resources.

Mr. Rozier asked members to review and to revisit the health planning areas and to determine whether any of the existing boundaries need to be changed.

Mr. Skelley questioned why Roosevelt Warm Springs Institute for Rehabilitation is not included in the inpatient rehab inventory. He said that they treat the same patients as other inpatient rehab providers.

Ms. Cartwright suggested that the average discharge rates for facilities should be reviewed in order to determine the minimum number of required beds for a new facility. She said that a facility that has traditionally maintained an average patient census of 20 patients would likely be averaging 10-11 patients after the 75% Rule is implemented. Members agreed that the issue of minimum bed size should be revisited at a future meeting.

Richard Greene questioned whether this is the appropriate time to rewrite the inpatient rehab Rules, given the current changes in the marketplace. He asked members to consider whether the TAC should delay the

development of the rules for another six to twelve months to see how industry changes are impacting the way providers deliver care.

Mr. Skelley said that there are some initiatives before Congress to keep the 50 Percent compliance threshold for two years, and to develop another approach, rather than implement the 75 Percent Rule. He said that regardless of federal guidelines and the changes in the market place, the state is currently significantly over-bedded. He said that the most important area that the TAC can address is how to improve statewide access to inpatient rehab services.

Mr. Greene said that the committee also could recommend a moratorium on inpatient rehabilitation beds.

Additional discussion ensued regarding how to account for the overlap services offered by LTACHs and inpatient rehab facilities. Mr. Greene pointed out that the Health Strategies Council (HSC) had recommended the formation of an LTACH TAC to create service specific rules. He suggested that instead of creating a separate TAC, new members from the LTACH provider community could be added to the Comprehensive Inpatient Physical Rehab TAC and some replacements could be made, particularly of those members that have not yet attended Rehab TAC meetings.

Members agreed to continue the discussion surrounding LTACHs at a future meeting.

FUTURE MEETING

The next TAC meeting is scheduled for **Friday, August 26, at 2 Peachtree Street, Atlanta, 34th Floor Conference Room from 1:00 pm-3:00 pm.**

Mr. Bauguess thanked all members for their participation in today's meeting and suggested that they encourage others not present at today's meeting to attend future meetings. He said that the TAC's work needs input from the wide cross-section of members.

There being no further business, the meeting adjourned at 3:30 pm.

Minutes taken on behalf of Chair by Geeta Singh and Stephanie Taylor.

Respectfully Submitted,

Harve Bauguess, Chair

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TECHNICAL ADVISORY COMMITTEE

Friday, July 29, 2005

APPENDIX A

WORKING DRAFT PROPOSED RULES

WORKING DRAFT PROPOSED RULES OF DEPARTMENT OF COMMUNITY HEALTH

111-2 HEALTH PLANNING

111-2-2 Certificate of Need

111-2-2-.35 Specific Review Considerations for Comprehensive Inpatient Physical Rehabilitation Services

(1) **Applicability.**

(a) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Adult Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Adult Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

(b) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Pediatric Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Pediatric Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

(c) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living (All Ages) Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living (All Ages) Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

Should TBI Transitional Living and Life Long Living Program Require Separate CONs and Separate Need Methodologies?

(d) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living (All Ages) Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living (All Ages) Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

Deleted: <#>A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Spinal Cord Disorders (All Ages) Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Spinal Cord Disorders (All Ages) Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.¶

(2) **Definitions.**

New Definition of Adult: 18+ For Medical Necessity: 16+

(a) 'Adult' means persons eighteen years of age and over. However, a CON-authorized Comprehensive Inpatient Physical Rehabilitation Adult Program will not be in violation of the CON laws and regulations if it provides service to a patient older than fifteen years if the provider has determined that such service is medically necessary, provided that the treatment days and patient census associated with patients sixteen and seventeen years of age do not exceed 10 percent of annual treatment days and annual census, respectively.

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(b) 'Comprehensive Inpatient Physical Rehabilitation Program' means rehabilitation services provided to a patient who requires hospitalization, which provides coordinated and integrated services that include evaluation and treatment, and emphasizes education and training of those served. The program is applicable to those individuals who require an intensity of services which includes, as a minimum, physician coverage 24 hours per day, seven days per week, with daily (at least five days per week) medical supervision, complete medical support services including consultation, 24-hour-per-day nursing, and daily (at least five days per week) multidisciplinary rehabilitation programming for a minimum of three hours per day. Throughout this Rule, whenever this general term is used, it refers to the full spectrum of programs delineated in Rule 111-2-2-.35(1)(a) through (f).

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Deleted: in that the patient has one or more medical conditions requiring intensive and interdisciplinary rehabilitation care, or has a medical complication in addition to the primary condition, so that the continuing availability of a physician is required to ensure safe and effective treatment.

New Definition of Expansion: Allows freestanding facilities to expand every two years without CON review if 85% Occupancy

(c) 'Expansion' and 'Expanded' mean the addition of beds to an existing CON-authorized Comprehensive Inpatient Physical Rehabilitation Program. However, a CON-authorized provider of Comprehensive Inpatient Physical Rehabilitation in a freestanding rehabilitation hospital or a traumatic brain injury facility may increase the bed capacity of an existing program by the lesser of ten percent of existing capacity or 10 beds if it has maintained an average occupancy of 85 percent for the previous twelve calendar months provided that there has been no such increase in the prior two years and provided that the capital expenditures associated with the increase do not exceed the capital expenditure threshold. If such an increase exceeds the capital expenditure threshold, the increase will be considered an expansion for which a Certificate of Need shall be required under these Rules.

(d) 'Freestanding Rehabilitation Hospital' means a specialized hospital organized and operated as a self-contained health care facility that provides one or more rehabilitation programs.

New Definition of New

(e) 'New' means a Program that has not provided Comprehensive Inpatient Physical Rehabilitation in the previous twelve months. Each of the programs described in 111-2-2-.35(1)(a) through (e) shall be considered independent programs such that a provider seeking to add a program not offered by that provider in the previous twelve months shall

be considered to be offering a new program for which a Certificate of Need must be obtained.

(f) 'Official State Health Component Plan' means the document related to Physical Rehabilitation Programs and Services developed by the Department, established by the Georgia Health Strategies Council and signed by the Governor of Georgia.

New Definition of Pediatric: 17- For Medical Necessity: 21-

(g) 'Pediatric' means persons seventeen years of age and under. However, a CON-authorized Comprehensive Inpatient Rehabilitation Pediatric Program will not be in violation of the CON laws and regulations if it provides service to a patient younger than twenty-two years if the provider has determined that such service is medically necessary, provided that the treatment days and patient census associated with patients eighteen, nineteen, twenty, and twenty-one years of age do not exceed 10 percent of annual treatment days and annual census, respectively.

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(h) 'Planning Area' means sub-state region for Physical Rehabilitation Programs and Services, as defined in the most recent official State Health Component Plan for Physical Rehabilitation Programs and Services.

Definitions Copied From Current TBI Rule

(i) 'Traumatic Brain Injury' means a traumatic insult to the brain and its related parts resulting in organic damage thereto that may cause physical, intellectual, emotional, social, or vocational changes in a person. It shall also be recognized that a person having a traumatic brain injury may have organic damage or physical or social disorders, but shall not be considered mentally ill.

(j) 'Traumatic Brain Injury Facility' means a building which is devoted to the provision of residential treatment and rehabilitative care in a transitional living program or a life long living program for periods continuing for 24 hours or longer for persons who have traumatic brain injury. Such a facility is not classified by the Georgia Department of Human Resources or the Department of Community Health as a hospital, nursing home, intermediate care facility or personal care home.

(k) 'Traumatic Brain Injury Life Long Living (All Ages) Program' means such treatment and rehabilitative care as shall be delivered to traumatic brain injury clients who have been discharged from a more intense level of rehabilitation program, but who cannot live at home independently, and who require on-going lifetime support. Such clients are medically stable, may have special needs, but need less than 24 hour per day medical support.

(l) 'Traumatic Brain Injury Transitional Living (All Ages) Program' means such treatment and rehabilitative care as shall be delivered to traumatic brain injury clients who require education and training for independent

living with a focus on compensation for skills which cannot be restored. Such care prepares clients for maximum independence, teaches necessary skills for community interaction, works with clients on pre-vocational and vocational training and stresses cognitive, speech, and behavioral therapies structured to the individual needs of clients. Such clients are medically stable, may have special needs, but need less than 24 hour per day medical support.

(3) Service-Specific Review Standards.

(a) The need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall be determined and applied as follows for the various types of Programs delineated in 111-2-2-.35(1):

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1. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Adult Program in a planning area shall be determined using the following demand-based need projection:

(i) Determine the number of Adult cases statewide in each of the CIPR Diagnostic Categories that were reported in the most recent complete year using the Georgia Discharge Data System or any data which is collected annually pursuant to O.C.G.A. 31-7-280(C);

(ii) Determine the Current Adult Utilization Rate by dividing the number of Adult discharges in each category by the concurrent year's Adult resident population.

Current Adult Utilization Rate = Current Adult Discharges / (Current Adult Resident Population / 1000)

(iii) Determine the Projected Adult Utilization Rate in the horizon year (five-years) by applying the Current Adult Utilization Rate to the horizon year's population.

Projected Adult Utilization Rate = (Projected Adult Resident Population / 1,000) X Current Adult Utilization Rate

(iv) Determine the number of projected adult admissions in the horizon year by applying the Projected Adult Utilization Rate against the Demand Factor percentage established for each category.

Projected Adult CIPR Admissions = Projected Adult Utilization Rate X Demand Factor Percentage

(v) Determine the Projected Adult Patient Days for CIPR in the horizon year for each category by applying the Projected Adult CIPR Admissions to the Expected Adult Average Length of Stay established for each category.

Projected Adult Patient Days = Projected Adult CIPR Admissions X Expected Adult Average Length of Stay

(vi) Add the Projected Adult Patient Days for each category to determine the Total Projected days for each CIPR Planning Area and then determine the number of beds needed if CIPR admissions utilized beds at 85% utilization.

Projected Gross Adult CIPR Beds = (Total Adult Projected Days/365) / 0.85

(vii) Determine the Net Projected Adult CIPR Beds needed in the horizon year by CIPR Planning Area by subtracting the Projected Gross Adult CIPR Beds from the Current Official Inventory of Existing and Approved Adult CIPR Beds for the Planning Area.

Net Projected Need/Surplus of Adult CIPR Beds = Existing and Approved Adult CIPR Beds - Projected Gross Adult CIPR Beds

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2. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Pediatric Program in a planning area shall be determined using the following demand-based need projection:

(i) Determine the number of Pediatric cases statewide in each of the CIPR Diagnostic Categories that were reported in the most recent complete year using the Georgia Discharge Data System or any data which is collected annually pursuant to O.C.G.A. 31-7-280(C);

(ii) Determine the Current Pediatric Utilization Rate by dividing the number of Pediatric discharges in each category by the concurrent year's Pediatric resident population.

Current Pediatric Utilization Rate = Current Pediatric Discharges / (Current Pediatric Resident Population / 1000)

(iii) Determine the Projected Pediatric Utilization Rate in the horizon year (five-years) by applying the Current Pediatric Utilization Rate to the horizon year's population.

Projected Pediatric Utilization Rate = (Projected Pediatric Resident Population / 1,000) X Current Pediatric Utilization Rate

(iv) Determine the number of projected pediatric admissions in the horizon year by applying the Projected Pediatric Utilization Rate against the Demand Factor percentage established for each category.

Projected Pediatric CIPR Admissions = Projected Pediatric Utilization Rate X Demand Factor Percentage

(v) Determine the Projected Pediatric Patient Days for CIPR in the horizon year for each category by applying the Projected Pediatric CIPR Admissions to the Expected Pediatric Average Length of Stay established for each category.

Projected Pediatric Patient Days = Projected Pediatric CIPR Admissions X Expected Pediatric Average Length of Stay

(vi) Add the Projected Pediatric Patient Days for each category to determine the Total Projected days for each CIPR Planning Area and then determine the number of beds needed if CIPR admissions utilized beds at 85% utilization.

Projected Gross Pediatric CIPR Beds = (Total Pediatric Projected Days/365) / 0.85

(vii) Determine the Net Projected Pediatric CIPR Beds needed in the horizon year by CIPR Planning Area by subtracting the Projected Gross Pediatric CIPR Beds from the Current Official Inventory of Existing and Approved Pediatric CIPR Beds for the Planning Area.

Net Projected Need/Surplus of Pediatric CIPR Beds = Existing and Approved Pediatric CIPR Beds - Projected Gross Pediatric CIPR Beds

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3. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living (All

Ages) Program in a planning area shall be determined [Methodology TO BE Described]

4. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living (All Ages) Program in a planning area shall be determined [Methodology TO BE Described]

Adverse Impact Standard: Will Cause a Facility to Drop 10% Utilization

(b) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall document that the establishment or expansion of its program will not have an adverse impact on existing and approved programs of the same type in its planning area. An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall have an adverse impact on existing and approved programs of the same type if it will decrease annual utilization by ten percent by the horizon year. The applicant shall provide evidence of projected impact by taking into account existing planning area market share of programs of the same type and future population growth.

Deleted: *5. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Spinal Cord Disorders (All Ages) Program in a planning area shall be determined [Methodology TO BE Described]*¶ ¶

Exception to Need and Adverse Impact: Only for Adult Programs? To Be Discussed

(c) The Department may grant an exception to the need methodology of 111-2-2-.35(3)(a)1 and to the adverse impact standard of 111-2-2-.35(3)(b) for an applicant proposing a program to be located in a county with a population of less than 40,000 and to be located a minimum of 50 miles away from any existing program in the state; or to remedy an atypical barrier to Comprehensive Inpatient Physical Rehabilitation Programs based on cost, quality, financial access or geographic accessibility; or if the applicant's annual census demonstrates 30 percent out of state utilization for the previous two years.

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(d) A new Comprehensive Inpatient Physical Rehabilitation Program shall have the following minimum bed sizes based on type of Program offered:

1. A new Comprehensive Inpatient Physical Rehabilitation Adult Program shall have a minimum bed size of 20 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 20 beds in an acute-care hospital, and 40 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program.

2. A new Comprehensive Inpatient Physical Rehabilitation Pediatric Program shall have a minimum of 10 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 10 beds in an acute-care hospital, and 40 beds for a new

freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program.

Minimum Bed Sizes for New Programs: To be Discussed and Verified

3. A new Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living Program shall have a minimum of 6 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 6 beds in an acute-care hospital, 6 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program, and 6 beds in a Traumatic Brain Injury Facility. A Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living Program may not have more than 30 beds unless the applicant provides documentation satisfactory to the Department that the program design, including staffing patterns and the physical plant, are such as to promote services which are of high quality, are cost-effective and are consistent with client needs.

4. A new Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living Program shall have a minimum of 6 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 6 beds in an acute-care hospital, 6 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program, and 6 beds in a Traumatic Brain Injury Facility. A Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living Program may not have more than 30 beds unless the applicant provides documentation satisfactory to the Department that the program design, including staffing patterns and the physical plant, are such as to promote services which are of high quality, are cost-effective and are consistent with client needs.

5. A new Comprehensive Inpatient Physical Rehabilitation Spinal Cord Disorders Program shall have a minimum of 20 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 20 beds in an acute-care hospital, and 40 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program.

Accreditation Standards

(e) An applicant for a new Comprehensive Inpatient Physical Rehabilitation Program shall demonstrate the intent to meet the standards of the Commission on Accreditation of Rehabilitation Facilities ("CARF") applicable to the type of Program to be offered within 36 months of offering the new service.

(f) An applicant for an expanded Comprehensive Inpatient Physical Rehabilitation Program shall be accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF") for the type of

Program which the applicant seeks to expand prior to application. The applicant must provide proof of such accreditation.

TBI Licensure Standards

(g) An applicant for a new Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living (All Ages) Program and/or a new Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living (All Ages) Program in a Traumatic Brain Injury Facility shall demonstrate the intent to meet the licensure Rules of the Georgia Department of Human Resources for Traumatic Brain Injury Facilities (Chapter 290-5-53). An applicant for an expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living (All Ages) Program and/or an expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living (All Ages) Program in a Traumatic Brain Injury Facility shall demonstrate a lack of uncorrected deficiencies as documented by letter from the Georgia Department of Human Resources.

(h) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall have written policies and procedures for utilization review. Such review shall consider, but is not limited to, factors such as medical necessity, appropriateness and efficiency of services, quality of patient care, and rates of utilization.

(i) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program in a Freestanding Rehabilitation Hospital or Traumatic Brain Injury Facility shall document the existence of referral arrangements with an acute-care hospital(s) within the planning area to provide acute and emergency medical treatment to any patient who requires such care.

(j) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall foster an environment that assures access to services to individuals unable to pay and regardless of payment source or circumstances by the following:

1. providing evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis;

2. providing a written commitment that un-reimbursed services for indigent and charity patients in the service will be offered at a standard which meets or exceeds three percent of annual gross revenues for the service after Medicare and Medicaid contractual adjustments and bad debt have been deducted;

3. providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to individuals unable to pay based on the past record of service to Medicare,

Medicaid, and indigent and charity patients, including the level of un-reimbursed indigent and charity care; and

4. providing documentation of current or proposed charges and policies, if any, regarding the amount or percentage of charges that charity patients, self pay patients, and the uninsured will be expected to pay.

Additional Financial Accessibility Standards

A provider offering more than one program in Comprehensive Inpatient Physical Rehabilitation may make one written commitment for the entire service as opposed to several commitments for the various programs within the service; however, an acute care hospital may not substitute an institution-wide commitment in lieu of this service-specific commitment.

k. In addition to the requirements of 111-2-2-.35(3)(j) an applicant for an expanded Comprehensive Inpatient Physical Rehabilitation Program shall be meeting or exceeding any and all previous commitments to indigent and charity care. If the applicant has not provided the level of indigent and charity care services sufficient to meet such commitments, the applicant may satisfy this requirement by paying a fine equal to the difference in the amount of services provided and the commitment made.

m. An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall agree to provide the Department with requested information and statistical data related to the operation of such a Program on a yearly basis, or as needed, and in a format requested by the Department.

Deleted: <sp><sp>l. A new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall be developed in a manner that improves the distribution of beds for similar Programs, existing or approved, within the planning area based on geographic and demographic characteristics.¶
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MINUTES
MEETING OF INPATIENT PHYSICAL REHABILITATION SERVICES
TECHNICAL ADVISORY COMMITTEE

Friday, July 29, 2005

APPENDIX B

SERVICE SPECIFIC NEED METHODOLOGY DOCUMENTS

- Comprehensive Inpatient Physical Rehabilitation: Updated Need Projection Components
- Comprehensive Inpatient Physical Rehabilitation: Need Projection Data Components from Component Plan
- Comparison of 2010 Comprehensive Inpatient Rehabilitation Need Projections, Using Existing Data Elements and Using Updated Data Elements
- Comprehensive Inpatient Rehabilitation Beds in Georgia per Capita Resident Population

Comprehensive Inpatient Physical Rehabilitation
Updated Need Projection Components

FOR DISCUSSION PURPOSES ONLY

Updated Discharge Rates and ALOS for the Comprehensive Inpatient Physical Rehabilitation and Spinal Cord Disorders Need Projection Methodology

Spinal Cord Disorders (All Ages)

Diagnostic Group	2003 Discharge Rate/1,000	Demand Factor	E-Rehab Average Length of Stay
Spinal Cord Disorders	0.12	40%	20

Inpatient Physical Rehabilitation Programs for Ages 0-14

Diagnostic Group	2003 Discharge Rates/1,000	Demand Factor	Average Length of Stay
Stroke	0.04	100%	12
Neurosystem Disorders	0.14	4%	21
Traumatic Brain Injury	0.29	8%	30
Non-traumatic Brain Injury	0.15	8%	30
Arthritis (Poly and Rheumatoid)	0.01	2%	5
Orthopedic Disorders	0.18	25%	20
Chronic Pain	0.05	0%	0

Inpatient Physical Rehabilitation Programs for Ages 15 and Up

Diagnostic Group	2003 Discharge Rates/1,000	Demand Factor	E-Rehab Average Length of Stay
Stroke	1.98	20%	18
Neurosystem Disorders	0.33	1%	21
Traumatic Brain Injury	0.56	2%	19
Non-traumatic Brain Injury	0.45	2%	16
Arthritis (Poly and Rheumatoid)	0.54	5%	23
Orthopedic Disorders	1.91	5%	11
Chronic Pain	2.29	1%	12

Sources:
2003 Discharge Data: Georgia Discharge Data System, Georgia Hospital Authority.
Demand Factor: Demand Factor is from the CIPR Component Plan
Average Length of Stay: ALOS for Spinal Cord Disorders and CIPR Adults is from E-Rehab and represents regional ALOS from January - June, 2005. The ALOS for Pediatric CIPR is from the Component Plan.

Comprehensive Inpatient Physical Rehabilitation
Need Projection Data Components from Component Plan

Data Elements of the Comprehensive Inpatient Physical Rehabilitation and Spinal Cord Disorders Need Projection Methodology

Spinal Cord Disorders (All Ages)

Diagnostic Group	1987 Discharge Rate/1,000	Demand Factor	Average Length of Stay
Spinal Cord Disorders	0.34	40%	32

Inpatient Physical Rehabilitation Programs for Ages 0-14

Diagnostic Group	1987 Discharge Rate/1,000	Demand Factor	Average Length of Stay
Stroke	0.13	100%	12
Neurosystem Disorders	0.69	4%	21
Traumatic Brain Injury	1.13	8%	30
Non-traumatic Brain Injury	0.51	8%	30
Arthritis (Poly and Rheumatoid)	0.07	2%	5
Orthopedic Disorders	1.04	25%	20
Chronic Pain	0.14	0%	0

Inpatient Physical Rehabilitation Programs for Ages 15 and Up

Diagnostic Group	1987 Discharge Rate/1,000	Demand Factor	Average Length of Stay
Stroke	3.89	20%	25
Neurosystem Disorders	1.13	1%	20
Traumatic Brain Injury	1.23	2%	40
Non-traumatic Brain Injury	1.19	2%	40
Arthritis (Poly and Rheumatoid)	1.31	5%	19
Orthopedic Disorders	4.06	5%	20
Chronic Pain	7.74	1%	12

Sources:
Discharge Rates, Demand Factor, and Average Length of Stay are specified in the CIPR Component Plan

Comparison of 2010 Comprehensive Inpatient Rehabilitation Need Projections Using Existing Data Elements and Using Updated Data Elements

FOR DISCUSSION PURPOSES ONLY

2010 CIPR Projection - Updated Discharge and ALOS

Planning Area	Ages 0 - 14			Ages 15 and Up			Spinal Cord Disorders	
	Beds Needed	Beds Available	Net Need or Surplus	Beds Needed	Beds Available	Net Need or Surplus	Beds Needed	Beds Available
PA 1	13	23	10	162	407	245	47	120
PA 2	2	8	6	27	180	153		
PA 3	1	0	(1)	24	164	140		
PA 4	1	0	(1)	20	97	77		
Statewide	**17**	**31**	**14**	**233**	**848**	**615**		

Prepared by: Data Resources and Analysis Section, Division of Health Planning

2010 CIPR Bed Need Projection - Using Current Methodology

Planning Area	Ages 0 - 14			Ages 15 and Up			Spinal Cord Disorders	
	Beds Needed	Beds Available	Net Need or Surplus	Beds Needed	Beds Available	Net Need or Surplus	Beds Needed	Beds Available
PA 1	55	23	10	467	407	245	134	120
PA 2	8	8	6	78	180	153		
PA 3	7	0	(1)	67	164	140		
PA 4	7	0	(1)	59	97	77		
Statewide	**77**	**31**	**14**	**671**	**848**	**615**		

Prepared by: Data Resources and Analysis Section, Division of Health Planning

Comprehensive Inpatient Physical Rehabilitation Beds in Georgia per Capita Resident Population				
CIPR Planning Areas	Current CON Capacity Beds in Inventory*			
	2005 Resident Population	Capacity Rehab Beds	Beds per 100,000	Residents per Bed
CIPR Area 1	6,063,163	430	7	14,100
CIPR Area 2	1,075,776	188	17	5,722
CIPR Area 3	945,792	164	17	5,767
CIPR Area 4	816,275	97	12	8,415
Statewide	**8,901,006**	**879**	**10**	**10,126**

Notes:

*Current Existing and Approved CIPR beds in official agency inventory as of 7/27/2005.

Prepared by: Data Resources and Analysis Section, Division of Health Planning